Developing World Bioethics ISSN 1471-8731 (print); 1471-8847 (online)
Volume 6 Number 2 2006 pp 59–70

SYMPOSIUM

JUSTIFIED COMMITMENTS? CONSIDERING RESOURCE ALLOCATION AND FAIRNESS IN MÉDECINS SANS FRONTIÈRES-HOLLAND

LISA FULLER

Keywords
NGOs,
resource allocation,
distributive justice,
justification,
special obligations

ABSTRACT
Non-governmental aid programs are an important source of health care for many people in the developing world. Despite the central role non-governmental organizations (NGOs) play in the delivery of these vital services, for the most part they either lack formal systems of accountability to their recipients altogether, or have only very weak requirements in this regard. This is because most NGOs are both self-mandating and self-regulating. What is needed in terms of accountability is some means by which all the relevant stakeholders can have their interests represented and considered. An ideally accountable decision-making process for NGOs should identify acceptable justifications and rule out unacceptable ones. Thus, the point of this paper is to evaluate three prominent types of justification given for decisions taken at the Dutch headquarters of Médecins sans Frontières. They are: population health justifications, mandate-based justifications and advocacy-based justifications. The central question at issue is whether these justifications are sufficiently robust to answer the concerns and objections that various stake-holders may have. I am particularly concerned with the legitimacy these justifications have in the eyes of project beneficiaries. I argue that special responsibilities to certain communities can arise out of long-term engagement with them, but that this type of priority needs to be constrained such that it does not exclude other potential beneficiaries to an undesirable extent. Finally, I suggest several new institutional mechanisms that would enhance the overall equity of decisions and so would ultimately contribute to the legitimacy of the organization as a whole.

Address for correspondence: Lisa Fuller, Department of Philosophy, University of Toronto, 215 Huron Street, Toronto ON, Canada M5S 1A1. lisafuller@canada.com

INTRODUCTION

Non-governmental aid programs are an important source of health care for many people in the developing world. In some areas, such programs are the only source of medical treatment, while in others they provide specific services meant to supplement the existing health care options. Despite the central role non-governmental organizations (NGOs) play in the delivery of these vital services, for the most part, they either lack formal systems of accountability to their recipients altogether or have only very weak requirements in this regard. In particular, NGOs typically have complete discretionary power over when and where to open, close, or implement serious changes to programs. This is because the majority of NGOs are both self-mandating and self-regulating.

However, given what is at stake for the recipients (or patients) in this context, we might object to this one-sided approach and instead maintain that aid recipients in the developing world are entitled to hold NGOs accountable for the decisions they make. At the very least we can say that they have a legitimate claim to be informed of the justifications for decisions that may affect them or their communities in a profound manner. Additionally, we might suppose that they have a legitimate claim to be able to appeal such decisions and to have their interests represented during deliberations. This is certainly a plausible claim to make with respect to populations that are currently receiving medical aid. It is also worth noting that populations without adequate access to medical care that are *not yet served* by health-care NGOs also have a vital interest in the outcome of such deliberations, and so it seems that they may be entitled to make similar types of claims.

Indeed, many NGOs are concerned about how they might improve accountability to their beneficiaries, but there is considerable disagreement among them about how this concern ought to be put into practice. This is reflected in a variety of self-regulatory mechanisms that have been recently proposed by (and for) NGOs. These mechanisms include the guidelines set out in *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response*[1] and the creation of a 'humanitarian ombudsman' who would represent the interests of aid beneficiaries.[2] Nevertheless, what *is* clear is that in order to generate accountability what is needed is some means by which all the relevant stakeholders can have their interests represented and considered. Further, an ideally accountable decision-making process for NGOs would have to identify acceptable justifications and rule out unacceptable ones. This is easier said than done. Thus, the point of this paper is to evaluate several types of justification given for decisions taken at the Dutch headquarters of Médecins sans Frontières (MSF). Since MSF is a leading medical and humanitarian NGO that is well known both for its expertise and its moral credibility, it seems reasonable to suppose that such an evaluation might prove a fruitful contribution to the discussion. Of course, the analysis provided here is only a small gesture in the direction of a full theory of NGO accountability to recipients in need of medical care.[3]

ABOUT MSF

MSF was founded in 1971, by several French doctors formerly of the International Red Cross (ICRC). They left the ICRC because they disagreed with its policy of maintaining strict silence concerning the forced starvation and migration that occurred during the war in Biafra. They wanted to be able to bear witness to the suffering of people, and to denounce their inhumane treatment. Solidarity with populations in danger is still one of the guiding values of MSF, as are principles of political, religious and economic independence, impartiality and humanity. While they assert their moral right to

[1] The Sphere Project. 2004. *The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response.* Geneva: The Sphere Project. Available at: http://www.sphereproject.org/ [Accessed 3 Feb 2006].

[2] This second mechanism has been proposed by what is now known as the 'Humanitarian Accountability Project'. See A. Ebrahim. Accountability in Practice: Mechanisms for NGOs. *World Development* 2003; 31: 821.

[3] A somewhat different version of this paper was printed for distribution within MSF in 2004. I also benefited from an opportunity to present it at the Joint Centre for Bioethics (University of Toronto) in April of that year.

denounce human rights abuses wherever they occur, and no matter who perpetrates them, they do not 'take sides' in a conflict situation. Instead, they treat victims on the basis of need. As such, they are also able to maintain a type of political neutrality in their dealings with parties in armed conflict.

Since its founding, MSF has grown to be a very large organization indeed. It has five operational sections based in Europe (Holland, France, Spain, Switzerland and Germany) and 13 partner sections worldwide. In general, operational sections are responsible for the actual design and implementation of projects, and partner sections focus their efforts on recruiting and fund-raising.[4] There is also an organization called 'MSF International', which is able to speak out on behalf of all sections and acts as a coordinating body.

The staff of MSF includes medical personnel (doctors, nurses, nutritionists, midwives, etc.) and several other types of personnel who are responsible for everything from financial and logistical matters to issues of human-rights advocacy and humanitarian law. While part of their mandate is the provision of humanitarian relief in emergencies, many of their relief programs are converted into long-term medical assistance projects after the initial emergency has been addressed. These can last for many years. MSF also intervenes in situations where the crisis is less acute, for instance, in areas of chronic political instability or where people are displaced for long periods of time. Typically, MSF works in areas of the developing world where no health care infrastructure exists, or where the existing infrastructure cannot adequately address the current needs of the population. Their regular activities include: mass vaccination campaigns, therapeutic and supplementary nutrition, distribution of drugs and supplies, surgery, the development of water and sanitation systems, and rehabilitation of health structures. At the time of writing, MSF was working in 68 countries.[5]

[4] I should note, however, that this precise division of labour is currently undergoing some changes since many partner sections have become quite large and are the source of significant expertise.

[5] More information on specific projects can be found at any one of the many MSF websites, including: http://www.msf.ca/; http://www.msf.org.au/; http://www.msf.org/.

ABOUT THE RESEARCH PROJECT

I began a collaborative investigation surrounding issues of ethics, principles and decision-making with MSF-Holland (MSF-H) in 2002. At that time, I spent several months in the field doing interviews, examining documents, attending meetings and visiting project sites. My observations took place mainly at the Nairobi office and at two field projects – one in Galcayo, Somalia, and another in Mandera, Kenya. On the basis of this first stage of my research, I produced a report that was subsequently presented in brief at MSF-H's annual 'Coordinator Days' conference in May of 2003.[6]

Immediately following the conference, I spent several weeks conducting additional research at MSF-H's head office in Amsterdam. At that time, I conducted approximately 10 semi-structured interviews that were audiotaped and transcribed with the consent of the participants. I was also assigned a limited functional role in their Humanitarian Affairs Department, in order to facilitate observation of the day-to-day activities of the office, and attended several meetings as a participant observer. Further, I attended some planning meetings where I was simply an observer and did not take part. Finally, I reviewed documents and reports from their on-site library, which enabled me to get a sense of how thinking about decision-making has changed over time in MSF-H.

The qualitative data upon which the following analysis is based was collected during this second phase of my research, although my prior knowledge of MSF-H was, of course, a useful background. Each phase of the research was approved separately by the research ethics committees of both the University of Toronto and MSF-H, and informed consent was obtained from the participants. I took a broadly grounded theory approach to analysis of the data. I first attempted to identify some of the key concepts used in discussions and reports concerning resource allocation. I then subjected these concepts to philosophical analysis, in an effort to

[6] See L. Fuller. 2003. *Many Missions, One Voice: Justice and Integrity in MSF Operational Choices.* Amsterdam: MSF. The output of this first visit was the above policy report in which I analyzed the meaning and importance of MSF principles and their relation to practice.

both clarify how these concepts and terms were used, and to build them into a larger conceptual framework. The three modes of justification analyzed below were found to be prevalent in the data taken as a whole, and each also appeared in more than one type of source (documents, interviews, and observations). As such, it can safely be said that they are recognized ways of reasoning within the organization, but also that they represent only *some* of the many justifications, arguments and views found there.[7]

Since my concern here is how headquarters-level resource allocation decisions are taken and the types of justifications that are given for them, it is necessary to say a few words about MSF-H's formal planning processes. Each year, a comprehensive set of project proposals is submitted to headquarters. These proposals are subject to review at the four-month and eight-month marks. In the annual proposals, each country manager submits budgets and objectives for all the projects in his or her country for the coming year. These budgets and objectives can be substantially altered during the scheduled reviews. In addition, other small budget allocations or emergency projects can be approved at either the weekly meetings of operational directors or, if the amount of money is small enough, on the sole authority of the relevant operational director. Operational directors oversee several countries at once and are answerable to the general director.

It is my understanding that each operational section has its own mechanisms for taking decisions, so the processes of other MSF sections will differ somewhat from those discussed here. As such, while the specific issues I raise should be taken to apply to the Holland section directly, the broad implications of my analysis may also be relevant to other MSF sections, and perhaps even to other NGOs that administer health-service aid projects.

[7] I would like to express my sincere thanks to all participants, as well as to MSF-H's Public Health Department for its role in facilitating this research. In particular, I would like to thank Richard Bedell and Lucie Blok for all their help and advice. Without their considerable support, this project would not have been possible. I would also like to thank L. Wayne Sumner for supporting my proposals to do field work, and my reviewers for their helpful comments.

ANALYSIS

Within the decision-making processes of MSF-H, justifications can take a variety of forms and represent several different interests or perspectives. The focus of my analysis here is specifically those justifications that are typically given for decisions to open, close, or substantially revamp a project. From my observations at both the field and headquarters levels, as well as my conversations with staff, it has become clear that these justifications can be divided into three main types: appeals to population health statistics, reference to the MSF mandate, and assurances that they would advocate on the communities' behalf. My main objective here is to provide an analysis of each of these from the point of view of fairness. For each mode of justification, I first provide a description of it, then raise some concerns about it, and finally, make some suggestions about how these concerns might be addressed.

But first, a word about justification. Why should we care about justification? Why not focus instead on the *results* of projects, such as the number of lives saved, vaccinations administered or the extent to which morbidity has been reduced? Because, when resources are limited, there is likely to be disagreement about how to set priorities both within and among projects. In order for the parties concerned to accept such priority-setting, it is important for them to recognize the decision-making process as legitimate. This acceptance is made more likely by the existence of a process that is both fair and transparent. After all, when people care deeply about the decisions being made, they cannot be expected to readily cooperate with decisions that they view as arbitrary or indefensible.[8]

A process of deliberation in which the reasons for decisions taken are both *available to all* stakeholders and *rationally defended* embodies what Norman Daniels & James Sabin call 'accountability for reasonableness'.[9] This is a more comprehensive notion

[8] It ought to be noted that mechanisms of procedural fairness do not, on their own, guarantee the production of a fair outcome in every case. I recognize that such procedural mechanisms might benefit from additional substantive criteria that define what can count as an acceptable outcome, thus eliminating at least the most obvious cases of unfairness. I do not suggest any such criteria here, however.

[9] N. Daniels & J. Sabin. 2002. *Setting Limits Fairly.* Oxford: Oxford University Press: 44.

of accountability than either simple financial reporting or assurances of cost-effectiveness, in that it is addressed to those people who may be adversely affected by certain decisions. To be accountable for reasonableness is to be accountable both to those people who benefit from decisions and to those who do not. This approach acknowledges that potential recipients of aid have a vital interest in MSF's decisions, while at the same time accommodating the fact that resources are limited and so not all suitable populations can be benefited. Caring about justification is, then, a way of caring about accountability to beneficiaries. To a lesser extent, it is also a way to build and protect the credibility of MSF-H, both in the eyes of its own members and the public at large.

(I) POPULATION HEALTH JUSTIFICATIONS

Several medical personnel reported that they have often given what they called 'population health' or 'public health' reasons for opening and closing projects. Such justifications are formed on the basis of population statistics, usually regarding a specific outbreak of a specific disease. For instance, when the statistical threshold which indicates that an outbreak is under control has been reached, this fact is presented as a good reason for closing the project. An MSF-er might argue thus: 'We came here for the outbreak, and we didn't concern ourselves with anything else. The outbreak is over, so we can leave. We have seen a clear improvement, we have done what we could do, and so the project is being closed'.

This type of 'medical' or 'public health' justification, when used with reference to a specific outbreak, seems relatively straightforward and unproblematic. This is because the value of the project rests with its outcome – control of the outbreak. In this situation, any relationship that is established with the communities is short-term and almost purely instrumental in nature. The desired end is what matters here.

By contrast, participants found this kind of justification for closing a project unsatisfactory when a general health care program was at issue, despite significant pressure to come up with medical reasons for leaving. One participant noted that he didn't feel that he had committed to a particular disease, or to a particular crisis, but rather, he said, 'I committed to helping people in this community'. Another participant commented:

> [A]s soon as you get involved in general health care to the population and there is no good government system or any other private system to take that over . . . it becomes much more difficult to say, 'Yes, but now it is no longer a big emergency here and there are bigger emergencies somewhere else in the world'. But what do you base that [judgment] on, that there is a bigger emergency somewhere else in the world? Often that is more based on the fact that there is an acute crisis there, and so what you are comparing is an acute crisis with a chronic crisis.

The basic message here is that many MSF-ers feel that if a community still needs them, then they have an obligation to stay. This sentiment was expressed particularly strongly by medical personnel. But why is this situation seen to entail a responsibility that is not present in the first case? After all, in both cases people were helped with their medical problems, and in both cases we can assume that at least *some* people were left who could have benefited from further assistance.

The second case differs from the first in the source of its value. In a program that consists of, or includes, general health care for people who have none, the value of the project is not exclusively in the end(s) it is intended to bring about.[10] Such projects have intrinsic value as well, as one participant explained: 'You are offering something to them, you are offering hope, you are offering possibilities of treatment and you can't leave in the middle of that'. Further, such projects express solidarity with a population in crisis, as well as engendering a relationship of trust between the community and MSF-H.[11]

Trust, hope, solidarity – these are all elements of the relation MSF-H has with a given population when its projects take on a more long-term and general form. It is in this relation then, that we can

[10] Of course, there is no doubt that such a project is also instrumentally valuable.

[11] For a much more in-depth discussion of the intrinsic goods embodied by MSF projects, see Fuller, *op. cit.* note 6.

locate the intrinsic value of the projects. In the philosophical literature, such a relationship is typically called 'special' since it identifies a relation between two particular groups that does not obtain between all human beings more generally. Importantly, such special relations are often said to be the source of special responsibilities as well. Samuel Scheffler makes the claim that, 'to attach non-instrumental value to my relationship . . . just is, in part, to see that person as a source of special claims'.[12] Scheffler unpacks this idea further by noting that to see some person or group as a source of special claims is to see their needs, interests and desires as 'providing me with presumptively decisive reasons for action, reasons that I would not have had in the absence of the relationship'.[13] He also points out that sometimes special responsibilities can originate in 'the vulnerability created by the beneficiary's trust in or dependence on the bearer'.[14] Either way, the result of special responsibilities is that we view certain people as being able to make special claims on us.

In essence, Scheffler is pointing out that our relations that have non-instrumental value require that we *give priority* to the interests of the people with whom we have them. This means that these reasons will usually trump competing reasons unless the others are very weighty indeed. If, for instance, the same amount of good could be done in a project elsewhere as in one where a relationship is already established, Scheffler is pointing out that the latter population would usually have the stronger claim. On this view, giving priority to those people with whom MSF-H is already engaged is part of what it means to be genuinely committed to helping *these particular people*, and not just to the project of helping more generally.

Scheffler's explanation provides a nice account of why many doctors and other field staff were uncomfortable with leaving a population when they had been providing the only general health care in the region. They seem to have instinctively felt that they had special obligations to the populations with which they were already engaged. Having begun providing these services and having established a relation of trust and solidarity with a certain population, MSF-H has come to owe them *something extra*, which it does not owe to others.

In fact, from my observations of how decisions were made at headquarters, it seemed that this intuition was usually taken to be a decent guide as to how to proceed. If a project or country is already established as a place where MSF-H is working, then the presumption is that it will continue unless decisive reasons can be provided for pulling out. While public health statistics might provide such a decisive reason in some instances, this is the case in only a small number of projects. As such, we can see that the population health justification has limited applicability.

The problem with relying heavily on a special obligations-type justification rather than a population health one, is that the former is vulnerable to what has been called 'the distributive objection'. Critics of special responsibilities worry that their effect 'may be to introduce injustice where there was none before'.[15] But how could this be so, if such responsibilities are generated by the value of the relation? Doesn't this value justify giving priority to people with whom MSF-H has already engaged?

That depends on the perspective one takes on the problem. From the perspective of safeguarding existing valuable relations, such a course of action seems best. However, the distributive objection takes what might be called a 'comparative' perspective. It is concerned not just with values and obligations that currently exist, but also with possible trade-offs that might be undertaken. The objection can be stated as follows:

> [Special] responsibilities confer additional advantages on people who have already benefited from participating in rewarding groups and relationships and . . . this is unjustifiable whenever the provision of these additional advantages works to the detriment of those who are needier, whether they are needier because they are not themselves participants in such rewarding groups or relationships, or because they have significantly fewer resources of other kinds.[16]

[12] S. Scheffler. 2001. *Boundaries and Allegiances*. Oxford: Oxford University Press: 100. The underlying assumption here is that relationships of solidarity and trust have intrinsic value, but I do not argue for that claim here, since such an argument would constitute a significant digression.

[13] Ibid: 100.

[14] Ibid: 104.

[15] Ibid: 92.

[16] Ibid: 85.

The concern is that having once been chosen to receive benefits, by virtue of the relationship that is subsequently developed, the same group is given priority status and so is made consistently better off than other comparable groups. This priority is said to be unfair.

So, how might this kind of concern for fairness be accommodated? If, as Scheffler asserts, it is not possible to 'obtain the benefits of participating in . . . relations without acquiring special responsibilities in the process', then any attempt to eliminate those relationships in the name of fairness entails the sacrifice of significant goods – intrinsically valuable ones.[17] Therefore, it seems useful to look for other ways in which to answer the distributive objection. Scheffler himself gestures at how this accommodation might be achieved; certain constraints could be put on relations that generate partiality such that third parties are less disadvantaged by them.

For this purpose, I would like to propose four plausible constraints: (1) a constraint on the *number* of such relations within the overall activity of MSF-H; (2) a constraint on their substantive *content*; (3) a *legitimacy* constraint, and finally; (4) a *reassessment* constraint.[18]

(1) The most obvious method by which to restrict partiality in programming is to designate a portion of the budget for new projects that will benefit populations not currently served. This allows them an ongoing opportunity to be considered for aid and so makes it impossible that partiality will lock them out altogether. Happily, MSF-H already does this each year by planning for 'an envelope of the unplannable'. Especially with respect to emergencies, MSF-H is committed to moving quickly into new areas and new countries, and reflects this commitment in its decision-making processes.

Of course, the central difficulty here is how to ascertain the appropriate size of the 'envelope', relative to the overall size of the budget. It is my understanding that within MSF-H, the budget allocation for new, unplanned projects is already substantial, and so is not merely a 'contingency' fund. While this practice is in line with a general commitment to restraining partiality, perhaps a more demanding (and instructive) way to formulate the problem is to ask: 'How much can we legitimately set aside for those projects that are already established?'[19]

(2) The content constraint is, on its face, simply an appeal to common sense. It can not be the case that continued partiality to a population is warranted if no real advantages are accruing to them as a result. In effect, the project must be meeting some needs; it should be benefiting the population in a substantial manner. Clearly some type of threshold must be specified in order to determine whether a given project is meeting this requirement. Just how much in the way of practical health benefits are required in order for the continuation of a particular project to be justified will depend on what other justificatory arguments can be made in its favour.

For instance, goods of an intrinsic nature should not be disregarded when evaluating any particular situation. It might be the case that some more lives could be saved if the funds from project *A* were reallocated to project *B*, but that in project *A* MSF-H is making a statement of protest by remaining to help this population when all other NGOs have abandoned them. This type of protest has moral value, and as such should count in favour of continuing project *A*.

The content constraint is a reflection of the fact that partiality is warranted by the values that it makes possible. The mere fact that MSF-H has been engaged with a given group of people for some time does not, in itself, generate any special obligations to them.[20] Projects must meet some minimum threshold of moral worth, usually by instantiating some combination of intrinsic value and positive health consequences for individuals.[21]

(3) The legitimacy constraint rests on the idea of reciprocity in relationships. In short, recipient populations must wish to have MSF-H present in their

[17] Ibid: 93.

[18] Another very important constraint is MSF's mandate or mission, but this is recognized as such by MSF-er's and so will be addressed in the next section as its own mode of justification.

[19] I owe this formulation of the problem to Nicholas Stockton.

[20] It is worth noting here that simple non-abandonment might be a good because it expresses solidarity. The importance or weight of this will vary with the situation of the population.

[21] The intrinsic value generated by a particular project could take the form of acts of protest, compassion or non-abandonment, for instance.

communities.[22] Scheffler notes that in order to value a relation non-instrumentally, it must be that I value the relation of each individual or group to the other.[23] It can't be the case that I value the status of MSF-H as a provider of certain goods but do not care who receives them or whether the recipients also value those goods. In the situation where other populations could benefit greatly from being chosen for aid, it seems illegitimate to be partial to ones that are either indifferent or hostile to MSF-H's presence. This is the case because the partiality originates in the value of the relation between MSF-H and the population. By definition then, if one party sees the relation as valueless (or even as having negative value), then the relation no longer exists as a source of special obligations. It does not have to be the case that members of the population say explicitly: 'We want you out', although this could be the situation. It is enough that no one in the relevant community cares one way or the other whether MSF-H stays or goes.

(4) The idea of a reassessment constraint might seem a little redundant given the extensive, ongoing evaluation of programs typical of MSF-H. However, from my observations at headquarters, it emerged that many of the reviews or decision-making forums are in fact approving changes that are already a *fait accompli* before they are considered. This makes a good deal of sense from an efficiency point of view, since changes to projects would be considerably delayed if they had to accommodate headquarters' schedule at every turn. Still, I was struck by the comment that it's never true that, 'everything is off the table, and we've got to start from scratch'. In my view, this betrays too deep an acceptance of the fact of partiality, even when it is open to the people involved to call existing projects into question if they wish.

From the perspective of third parties who might potentially benefit from less partiality, it would be fairer to deliberately call into question every project (or perhaps country) on some kind of regular, rotating basis.[24] This would mean that at scheduled intervals MSF-H's presence in a given country would be thrown into question and people would have to make a case for it 'from scratch'. If their presence in a given country were approved anew on this basis, then the ongoing nature of the relationship surely would add more weight to that verdict. If it turned out that MSF-H's presence there was borderline or was rejected, then factors about the historical relation between MSF-H and that population might be brought up as part of an appeal, or counter-argument. Depending on the case, the historical relationship might be enough to tip the scale in the direction of approval, or it might not.

This constraint is a suggestion about how to level the playing field in favour of those populations not currently part of MSF-H's portfolio. Having intermittent evaluations of this radical sort would eliminate the dependence in the present system on the willingness of certain individuals to question particular commitments. After all, any particular individual's willingness to question is dependent on many contingent factors, such as workload, assertiveness, and personal attachment. As such, their failure to raise concerns may not reflect their reasoned opinions, and so introduces an undesirable element of arbitrariness.

(II) MANDATE-BASED JUSTIFICATIONS

Among the MSF-ers with whom I spoke, the most recognized constraint on the choice of activities and populations was the mandate. While MSF's mandate, or 'mission', is not a rigidly interpreted set of requirements, it is seen by most people to have both ascertainable boundaries and significant weight. As such, it is often cited as the justification for ruling out certain activities or populations as appropriate for MSF-H involvement. One participant explained that for MSF-H to begin a program in a given location, 'it has to have this combination of humanitarian and medical crisis'. At least for the purposes of new projects, it is not enough that there are medical needs – there also must be a natural or social

[22] Of course, it is not always easy to determine exactly whose opinion represents the view of the community. Certainly the opinions of authority figures should not be the only ones considered. At the very least, the people most affected by the presence of MSF should place some value on their efforts.

[23] Scheffler, *op. cit.* note 12.

[24] This is, admittedly, merely a slightly more radical version of what already goes on.

upheaval of some sort that is making certain people more vulnerable than they would otherwise be. Further, since MSF is both a medical organization and an emergency organization, these ideas are also central parts of the mandate and so serve to delineate MSF-H's sphere of action. When asked why they will not set up a project or undertake a particular activity, the answer can (sometimes) simply be that 'It is not in line with who we are'. Answers of this form are what I am calling 'mandate-based justifications'.[25]

The amount and source of the mandate's flexibility are what make it an interesting – if sometimes problematic – type of justification. I have argued elsewhere that only if changes in interpretation are made on principle, and for the long term, can the mandate survive as a legitimate source of justification.[26] This is because the mandate is meant to direct MSF-H's efforts toward the realization of certain goods, and so its use as a constraint on activities is only reasonable if it actually realizes those goods over the long term.[27] Arbitrary or unprincipled changes in the way the mandate is construed can undermine the validity of this type of argument. This is because only consistent application of this constraint can show it to be procedurally fair.

Still, this does not mean that interpretation of the mandate cannot change over time, although such changes do represent a challenge for fairness. Both Ronald Dworkin and Norman Daniels argue that it is possible to take a 'case law' approach to past policy decisions while still retaining the ability to make innovative changes. This approach rests on two fundamental premises: (1) 'a presumption that the earlier, reason-based deliberation will be applied to similar cases in the present'; (2) the claim that 'respect for past commitments . . . does not mean that past errors of judgments cannot be corrected by new deliberation'.[28] These two premises can be understood to give weight to both the 'history' and 'integrity' of the process.[29] The first recognizes the basic requirement of procedural fairness that like cases should be treated alike, while the second acknowledges that substantive moral considerations may require past mistakes to be corrected. This approach requires that changes in the interpretation of the mandate be backed up by moral reasons, since this also changes which populations and activities will fall under it. Daniels & Sabin explain:

> [The] case law [approach] does not imply past infallibility, but it does imply giving careful consideration to why earlier decision-makers made the choices they did. Since treating a new case differently from a (similar) old one thus involves acknowledging a change and perhaps an earlier error in policy, the case law model demands a clear rationale and a new avowal of principles and commitments in order to avoid the appearance of inconsistency or deliberate unfairness in treatment.[30]

The mandate is not shaped exclusively by internal mechanisms and concerns. It is also sensitive to moral demands coming from outside. This type of sensitivity tends toward the improvement of the mandate as a justifiable constraint, since it can be adjusted to address substantive moral concerns that present themselves at the field level. One such change in mandate seems to have occurred with respect to differentiating exit and entry criteria. One participant noted that a combined humanitarian and medical crisis used to be seen as both an *entry* and an *exit* criterion. However, it was noted that this 'doesn't feel right especially for the medical people'. As a result, the policy had been changed by 2003 such that, as one participant put it, 'if there is still a medical crisis, even though the humanitarian crisis may have resolved, we will not just leave it like that'.

[25] A note about the word 'mandate'. Officially, MSF doesn't have a rigidly defined, written mandate. They prefer not to because this allows for more flexibility and growth. However, having an informal mandate or mission of this kind only makes the problem of how it can function as a constraint or justification more acute, rather than less.

[26] See Fuller, *op. cit.* note 6.

[27] The fact that these goods have substantive value is what justifies directing action towards their realization in the first place. Their value is a sufficient reason to choose them, since it is unreasonable to expect that any organization will be able to take on all the goods that would be worthwhile pursuing.

[28] Daniels & Sabin, *op. cit.* note 9, p. 48.

[29] 'History' and 'integrity' are Dworkin's terms, rather than Daniels' (see Ronald Dworkin. 1986. *Law's Empire*. Cambridge, MA: Belknap Press.) However, they are a nice shorthand way of referring to the two elements of justice which both philosophers are concerned to incorporate into decision-making, namely, procedural justice and substantively just outcomes.

[30] Daniels & Sabin, *op. cit.* note 9, p. 48.

It appears from the above example that organizations cannot be the 'supreme gatekeepers of [their] own identities'.[31] Although we may choose to begin or end certain relations, it is not always up to us what moral significance they take on. Scheffler notes that relationships have a strong 'influence [on] the ways that we are seen by both ourselves and others'.[32] This is an advantage from the point of view of accountability. Having a mandate that is sensitive to relevant outside factors helps counter the objection that mandates are too inward looking to act as a justifiable reason for choosing some populations and not others.[33] Making room for the continual revision and re-shaping of the mandate in light of new concerns is a way to answer this objection, by demonstrating that the mandate is actually a 'middle-way' between the priorities set by the organization and those demanded by the needs and circumstances of the recipients.

(III) ADVOCACY-BASED JUSTIFICATIONS

The third type of justificatory argument frequently cited by participants was 'the advocacy justification'. This argument was used to support projects meant to demonstrate that certain treatments can be successfully delivered in difficult or unusual settings. It can be the case in these projects that only a few people are provided with extensive treatment, while others receive virtually none. These are sometimes called 'vertical' programs, and generally address complex diseases such as, for example, multi-drug resistant tuberculosis. This model was characterized by one participant as, providing: 'Cadillacs for some [patients, instead of] bicycles for all'.

The advocacy justification runs, roughly, as follows: 'In this project we are setting an example by demonstrating that such-and-such a treatment can be successfully carried out in a resource-poor setting. On this basis we will then advocate for the Ministry of Health (MoH) and/or other agencies and political actors to stop neglecting their responsibilities with respect to people afflicted with this type of ailment'. While this is a very worthwhile thing to do in principle, one participant wondered, '[i]f these projects do not have advocacy consequences, are they really justified?' This is a worry about whether providing treatment for only a few people who have complex diseases – in a context in which many others have no access to treatment at all – is morally justifiable unless it results in a lot more good consequences in the long run. If, as people hope, the government or MoH takes up the new treatment, and so results in good outcomes for many more members of the population, then the original vertical program appears to be justified. If, as often happens, the treatment is not taken up and applied on a larger scale, then it seems like using so many resources to treat only a few people was simply unfair.

Obviously one of the key problems here is uncertainty about future consequences. Unfortunately, moral decisions and evaluations are typically made under uncertain conditions and so this does not do much to alleviate people's moral concerns.[34] To avoid this problem, we, as agents, often strive to make decisions that mitigate the negative effects of uncertainty on the overall value of the action.

How do we do this? We undertake actions that have a number of different valuable aspects. For instance, in evaluating vertical programs, several different values ought to be considered. First, if the project is genuinely groundbreaking from a scientific point of view, then this has value independently of

[31] Scheffler, *op. cit.* note 12, p. 107.

[32] Ibid: 106.

[33] The idea that the mandate can and should be constrained by factors outside the organization might seem unusual or objectionable to some. It is often thought that the giver of 'charity' is free to decide to whom s/he will give, how much, and when. This approach seems unduly dismissive of the interests of recipients since it suggests that they are not entitled to a say in actions that greatly affect them. Indeed, for similar reasons this prevalent view also does not express sufficient respect for the beneficiaries as the moral equals of the NGO decision-makers. Finally, it is important to note a significant difference between the case of the isolated, private giver and the situation of an NGO. It seems much more plausible to argue that 'if you are in the ongoing business of providing aid, then you ought to do so in an accountable and ethically justifiable manner' than it is to argue that private individuals ought to be held to such standards (although perhaps this argument could be made). The institutional character of NGOs, coupled with the significant effects they have on a large number of people provide presumptive reasons in favour of more stringent ethical requirements for them.

[34] Unless, of course, certain consequences were altogether unforeseeable, and then we do no typically hold anyone responsible for them. We do, however, still take into account the degree of uncertainty people were facing when they made the decision, and evaluate whether or not it was a wise one under the circumstances.

whether more members of the population are subsequently treated. Also, the fact that MSF-H has demonstrated the feasibility of a new treatment reveals that the MoH (or other responsible parties) could be helping these people but simply *will not*. This has value as an act of moral protest and solidarity with the people who continue to suffer needlessly. These considerations can go some distance toward justifying certain kinds of vertical projects even when it is uncertain whether or not other good health outcomes for individuals will result in the long term.

Nevertheless, it may be the case that strictly vertical programs are always a problem for fairness. When there is a high prevalence of common diseases in the population that are easy and inexpensive to treat, equity does seem to demand that they be addressed somehow. Pairing each vertical program with a general health care unit would go a long way to satisfying the demands of equity while retaining the other benefits of these projects. In this situation, it would never be the case that uncertainty about the future impacted severely on MSF-H's ability to justify its activities in retrospect.

CONCLUSION: INTEGRATING INDIVIDUAL AND INSTITUTIONAL APPROACHES

We have seen that within MSF-H justifications serve a variety of purposes. Justifications are made by individuals to beneficiaries, by individuals to other MSF members (including members of other operational sections), and sometimes even by individuals to themselves. Furthermore, the activity of giving justifications takes place within an institutional framework that serves two functions. First, it is the source of demands upon individuals to give reasons and arguments. It determines when and how such arguments will be given, and provides decision-makers with an opportunity to discuss and consider their merits. Second, the institutional framework itself can be structured such that it facilitates fairness in resource allocation. Headquarters level procedures can greatly contribute to the overall justifiability and legitimacy of the organization, if they are oriented toward balancing current commitments with other potential commitments.

One way to understand how the decision-making process can achieve this balance, is to think of it as embodying two distinct perspectives simultaneously – the 'comparative' and the 'relational'. The comparative perspective is both impersonal and impartial, in that it abstracts from any concrete relationships MSF-H might have and focuses instead on factors such as the level of need present in the populations and the likelihood of securing good outcomes for them. It is also sensitive to the *distribution* of good consequences among the pool of potential and actual beneficiaries (recall that the comparative perspective is taken by the distributive objection mentioned earlier). The 'relational' perspective is the perspective of people who have established a significant relation with a given community. Here, justification is understood as the concrete practice of giving reasons for project decisions directly to recipients, and listening to their objections. From this perspective, it is no longer open as a justificatory strategy to compare the needs or circumstances of this *particular* group with some other group in an impersonal manner. Only reasons specific to their context and MSF-H's concrete capacities are likely to be found acceptable at this level. This is because decisions regarding jointly-held goods such as trust and cooperation are only likely to be viewed as legitimate if all concerned parties are treated equitably – that is, given a voice and an opportunity to raise concerns.

Indeed, the division between field and headquarters staff seems ideally suited to embodying these two perspectives. However, since most people at headquarters have extensive field experience (and so are extremely sympathetic to that point of view), some adjustment in outlook might need to be made on their part in order to make the system as a whole more fair.[35]

Field staff are in the best position to argue from the relational perspective. They have the necessary knowledge and experience with particular communities to assess the degree of dependence, trust, cooperation and vulnerability present within them. As such, they will be able to articulate reasons

[35] While this division of labour between field and headquarters might be a bit artificial, it does seem to have some intuitive appeal. Clearly though, what is important is that both perspectives ultimately be represented in the decision-making process.

why special obligations obtain, and what might be required to fulfill them. Field staff are also the people who ultimately have to give explanations to beneficiaries when changes or closures are going to be instituted. Since this is quite a heavy burden, they should be able to demand justifications from headquarters that they can understand and can feel satisfied giving on behalf of the whole organization. By making this type of demand, they are standing up for the interests of those particular beneficiaries, and also reassuring themselves that the strategy being implemented is not simply arbitrary – both of which are desirable activities from the point of view of ethical reasoning. With the exception of security concerns, there does not seem to be any reason why field staff should have to work on the assumption that, as one participant put it: 'maybe headquarters knows better why the choice was made'. For that matter, the practice of giving genuine and acceptable reasons for a change in policy to recipients is a fundamental aspect of treating them with respect, and so such reasons should be demanded by staff on that basis also.

By contrast, it is up to decision-makers at headquarters to put a structure in place that takes the concerns of the comparative perspective into account. This can be achieved by taking up a 'third-party' viewpoint, or that of other potential beneficiaries. I have suggested that the interests represented by this standpoint might be best served by instituting a set of constraints on the relational perspective – by constricting the scope of allowable partiality to current commitments.

This could be achieved in a number of ways. For instance, headquarters can act (and already does) as the final arbiter on issues of expanding or reinterpreting the mandate, which in turn, requires people in the field to make their arguments compatible with it.[36] If these revisions were undertaken with an eye to representing the interests of communities *not yet* served, it could be a very effective mechanism for counter-balancing the tendency to privilege current commitments. Additionally, I have suggested several other constraints: (1) allotting a certain amount of funds for the needs of new populations such that existing entitlements do not shut out other groups; (2) evaluating the content of programs in a sophisticated manner in order to ensure that the priority they are given is based on the real values they instantiate; (3) instituting some kind of review process that does not take existing commitments for granted but rather subjects them to radical questioning on a periodic basis.

While these types of measures do not eliminate the priority that seems to be routinely given to established programs, they would act as a kind of check on it. In any case, it does not seem appropriate to take the comparative perspective at all times, and so what is needed is a kind of balance of those responsibilities engendered by special relationships and those obligations owed to people in general. If each perspective were taken up and defended vigorously, then the result should be an acceptable compromise between conflicting obligations. As Thomas Christiano writes:

> [J]ustice strikes an appropriate balance between the interests of individuals when they conflict. It gives each person a claim to his or her share . . . The appropriate balance between these conflicting interests is given by the idea of equal consideration of interests.[37]

Dividing up responsibility for advancing claims arising from the comparative and relational perspectives allows for the important interests of both current and potential beneficiaries to be considered equitably. The compromise that will likely result from such a process will be backed up by reasons and will reflect a concern for both particular commitments and overall fairness. This, in turn, will strengthen MSF-H's credibility as an organization committed to both impartiality and to expressing solidarity with populations in danger.

[36] Of course, this needs to be done in conjunction with other MSF sections as well.

[37] T. Christiano. Knowledge and Power in the Justification of Democracy. *Australas J Philos* 2001; 79: 202.